CHRYSTAL MEDICAL

Endoscopy plus
From Vanguard Healthcare Solutions

A new, integrated approach to endoscopy capacity

Regional disparities in endoscopy services in England

Why rural, low-income and marginalised communities cannot wait for diagnostic recovery

Executive summary

Endoscopy is a foundational diagnostic service for cancer pathways, screening follow-up and the investigation of gastrointestinal symptoms. Yet the latest official DM01 provider data shows that in January 2026, England had **199,681 people waiting for one of the DM01 endoscopy tests** (colonoscopy, gastroscopy, flexible sigmoidoscopy and cystoscopy), with **62,562 waiting six weeks or more.** That means **31.3%** of endoscopy patients were breaching the six-week diagnostic standard at month end, far above the operational standard of less than 1%.

These pressures are not evenly distributed. Using the same DM01 provider dataset, the percentage of endoscopy patients waiting six weeks or more ranged from **21.4% in the North West to 39.2% in the South East,** with the Midlands (35.2%) and East of England (34.8%) also significantly above the national endoscopy average. The rate of very long waits (13+ weeks) varied even more, reaching **21.6% in the South** East versus **6.5% in the North West.**

If England is serious about returning to the diagnostic constitutional standard, endoscopy recovery must be designed and delivered through a health inequalities lens. That means using DM01 to identify hotspots, structuring capacity so it can be deployed rapidly to where the burden is greatest, and ensuring rural, deprived and marginalised communities are not structurally disadvantaged by geography, transport barriers and workforce shortages.

Executive opening paragraph

Where a patient lives should not determine how quickly they receive a potentially life-saving endoscopy. Yet, in practice, access to timely endoscopy in England varies widely, and this variation risks widening existing health inequalities. When endoscopy capacity is tight, the impact is never neutral: the communities that are already least able to overcome distance, time off work, car access, language barriers or unstable housing are also the most likely to experience delayed diagnosis and delayed treatment.

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What the latest DM01 data shows about regional variation in endoscopy waits

NHS England's DM01 monthly diagnostics collection provides the most consistent, comparable view of diagnostic waiting times and activity, including key endoscopy tests. In January 2026, NHS England reported a national diagnostic backlog of 1**,810,900 people waiting for a key diagnostic test,** with **447,100 waiting six weeks or more (24.7%)**, confirming the constitutional standard is not being met.

Endoscopy is under even greater strain than diagnostics overall. In January 2026, national DM01 metrics show high rates of six-week breaches for endoscopy tests: **33.1% for colonoscopy, 33.9% for flexible sigmoidoscopy, 30.2% for gastroscopy, and 27.2% for cystoscopy.**

When the DM01 provider dataset is aggregated by NHS England commissioning region (using the "Regional Team Name" field), the inequalities become clearer:

- **South East:** 39.2% of endoscopy patients waiting 6+ weeks; 21.6% waiting 13+ weeks.
- **Midlands:** 35.2% waiting 6+ weeks; 17.6% waiting 13+ weeks.
- **East of England:** 34.8% waiting 6+ weeks; 14.6% waiting 13+ weeks.
- **North West:** 21.4% waiting 6+ weeks; 6.5% waiting 13+ weeks.

These regional blends also conceal concentration of pressure in specific provider hotspots. A simple analysis of the January 2026 DM01 provider file shows that **25 provider organisations account for approximately 63% of all endoscopy 6+ week waits in England.** In other words, the backlog is heavily clustered, which creates an opportunity for targeted, high-impact interventions, particularly if capacity can be mobilised quickly.

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Why disparities persist in rural, deprived and marginalised communities

Rurality and travel barriers

Rural and remote communities often face longer travel times to reach acute hospitals, and this can translate into delayed presentation, missed appointments, and lower engagement with planned care. Evidence from England has shown how geographic remoteness increases distance and drive-time to acute hospitals, with rural areas in the South West among those most remote from district general hospitals.

Broader evidence across developed health systems also supports the relationship between distance or travel time and reduced access to healthcare services for rural and remote residents, reinforcing why "where services are located" matters as much as "how many lists are offered".

Endoscopy is particularly sensitive to travel barriers because patients may need bowel preparation, escorts (especially if sedated), and follow-up. When travel is expensive, lengthy, or dependent on unreliable transport, delays disproportionately affect those already facing disadvantage.

Deprivation and unequal participation in screening and follow-up

Health inequality is not only about illness. It is also about unequal access, unequal participation and unequal ability to navigate complex pathways. NHS England's Core20PLUS5 approach explicitly defines the "Core20" as the most deprived 20% of the national population (by Index of Multiple Deprivation) and requires targeted action to reduce healthcare inequalities.

For bowel cancer screening, official programme reporting shows that uptake is socially graded. In 2023–24, the NHS Bowel Cancer Screening Programme recorded 6,969,227 invitations and an uptake of 67.6%, and it explicitly reports that participation is lower among people living in the most deprived areas.

This matters operationally for endoscopy because FIT-based screening generates downstream demand for colonoscopy in patients needing further tests. The same official report records 83,112 people with a result indicating "further tests are needed" who were automatically referred, creating a clear demand signal for timely diagnostic follow-up capacity.

Marginalised groups and inclusion health

NHS England also highlights "inclusion health groups" as populations that experience poorer than average access, experience and outcomes, reinforcing the need for systems to tailor delivery models for people at highest risk of being left behind.

For endoscopy recovery, this points to practical design questions: where clinics are located, how appointments are offered, what transport support exists, and whether pathways accommodate patients with unstable housing, limited digital access, or complex social need.

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Workforce shortages and fragile service resilience

Capacity is not simply rooms and equipment. It is lists that run consistently. Workforce remains one of the central constraints. The British Society of Gastroenterology's 2024 workforce report notes that **74% of responding departments reported a consultant vacancy,** a meaningful indicator of fragility in the workforce base needed to deliver endoscopy activity.

Workforce constraints interact with geography. Recruitment and retention can be harder in rural, coastal and remote areas, and even where staff are available, reliance on ad hoc capacity makes sustained recovery difficult.

Clinical impact of delayed endoscopy

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What works in practice: mobile and modular endoscopy capacity deployed to hotspots

Swindon: modular community endoscopy capacity closer to patients

In Swindon, Vanguard delivered a modular Community Diagnostic Centre endoscopy facility designed to relieve pressure on the acute hospital and improve timeliness. The plan included **two endoscopy treatment rooms** and **six patient pods for preparation and recovery**, alongside consultation and support spaces. The facility was intended to welcome **6,000 patients over 12 months,** and the modules were installed over **two days** to minimise disruption.

This case illustrates how community-located, purpose-built endoscopy capacity can reduce access barriers by bringing services closer to where people live and work, which is particularly significant for patients who struggle with travel, time off work, or hospital-site accessibility

Fairfield General Hospital, Bury: rapid regional recovery capacity

In Greater Manchester, Vanguard delivered a dual-procedure endoscopy suite at Fairfield General Hospital with two **procedure rooms**, a **6-bed recovery bay,** and consulting rooms, operating **7 days a week** for colonoscopy, sigmoidoscopy and gastroscopy. The service model included a workforce partnership with **18 Week Support,** providing specialist endoscopy nurses and consultants, while the Trust provided reception and porter services.

In its first six months, the unit supported patients from multiple Trusts across the region, demonstrating how deployable capacity can be used as mutual aid, concentrating volume where it can be delivered quickly. The case study also reports list productivity in JAG points (around **48–52 JAG points per day**) and indicates that waiting times reduced considerably.

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How Endoscopy Plus can help reduce regional disparities

Endoscopy Plus is Vanguard's integrated endoscopy capacity proposition, bringing together **flexible endoscopy facilities, clinical expertise, service management and workforce support under a single Vanguard-led model.** This model is explicitly positioned to move beyond infrastructure-only solutions when systems need a faster route to safe, reliable throughput.

For regional disparities, the practical value is that deployable capacity can be targeted at hotspots and adjusted as pressure shifts, informed by DM01. This aligns with NHS England's emphasis on using demand and capacity models to understand demand variation, capacity requirements, and backlog clearance needed to meet waiting time standards.

Indicative regional estimate: how many two-room mobile units might be needed?

The table below provides an illustrative estimate of how many two-room deployable endoscopy units could be required by NHS England commissioning region to reduce endoscopy 6+ week waits to less than 1%. It is based on January 2026 DM01 provider data and a conservative throughput assumption informed by the Swindon two-room endoscopy facility planning expectation of around 6,000 patients per year.

Assumptions (explicit):

- Baseline is DM01 endoscopy tests (colonoscopy, gastroscopy, flexible sigmoidoscopy, cystoscopy) at month end, January 2026.
- Target is for 6+ week waits to equal 1% of the endoscopy waiting list (the operational standard).
- Each two-room unit delivers 6,000 additional procedures per year when staffed and utilised illustrative, case-mix dependent).
- The estimate treats "excess 6+ week waits above 1%" as the backlog to be cleared within 12 months, without modelling new inflow, triage changes, or substitution effects. It is therefore directional, not definitive.

NHS England commissioning region	Endoscopy waiting list (Jan 2026)	Endoscopy waits 6+ weeks	% waiting 6+ weeks	Excess 6+ weeks above 1% standard	Indicative two-room units to clear excess in 12 months
South East	31,945	12,534	39.2%	12,215	3
Midlands	34,517	12,152	35.2%	11,807	2
East of England	26,032	9,067	34.8%	8,807	2
North East and Yorkshire	31,184	9,237	29.6%	8,925	2
London	29,505	7,728	26.2%	7,433	2
South West	20,329	6,254	30.8%	6,051	2
North West	26,169	5,590	21.4%	5,328	1
England total	**199,681**	**62,562**	**31.3%**	**60,566**	**14**

Source: Author calculations from NHS England DM01 Monthly Diagnostics Provider dataset (January 2026).

Conclusion

Returning to constitutional diagnostic standards will require more than simply increasing the overall number of procedures delivered across England. It will require a deliberate focus on **where capacity is located and who can access it.** Rural communities, areas of high deprivation and marginalised populations often experience the greatest barriers to timely investigation, whether through travel distance, workforce shortages or historic underinvestment in diagnostic infrastructure. Addressing these disparities means designing a system that can respond dynamically to changing demand, using data such as the NHS DM01 diagnostics dataset to identify hotspots and deploy capacity where it will make the greatest difference.

Flexible infrastructure and integrated service models provide an opportunity to do exactly that. Solutions such as **Endoscopy Plus,** supported by Vanguard's mobile and modular endoscopy fleet, enable healthcare systems to expand diagnostic capacity rapidly and deploy it to areas of greatest need. Mobile facilities can be installed quickly and operate for defined periods in locations experiencing the highest demand, before being redeployed elsewhere as pressures shift. Combined with clinical expertise and operational support, this approach offers a practical route to improving access to endoscopy services, reducing waiting times and ensuring that progress towards the six-week constitutional standard benefits patients across every community, not only those living close to major hospital centres.